pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **PERSONAL CARE AT EVERGREEN INC**
LEGAL ENTITY

To operate **PERSONAL CARE AT EVERGREEN**
NAME OF FACILITY OR AGENCY

Located at **336 NORTH MAIN STREET, WASHINGTON, PA 15301**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **48** (MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions:

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **October 11, 2024** until **April 11, 2025**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **405781**

ISSUING OFFICER

Juliet Marsala
ACTING DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628P – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: OCTOBER 11, 2024

[redacted]
Personal Care at Evergreen, Inc.
336 North Main Street
Washington, Pennsylvania 15301

RE: Personal Care at Evergreen
License/COC #: 405781

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on April 2, 2024, April 16, 2024, and June 14, 2024, of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), failure to submit an acceptable plan to correct noncompliance items, and failure to comply with the acceptable plan to correct noncompliance items, the Department hereby REVOKES your certificate of compliance (license number 405780) dated April 20, 2024 – April 20, 2025, and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1) and 55 Pa. Code § 20.71(a)(2); (3); (4) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from October 11, 2024 to April 11, 2025.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

If you disagree with the decision to issue a PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. If you decide

to appeal your PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

[redacted]
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
PH: 717-265-8942

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted]

Department of Human Services
Bureau of Human Service Licensing

LICENSING INSPECTION SUMMARY - PUBLIC

Facility Information

Name: *PERSONAL CARE AT EVERGREEN* **License #:** *40578* **License Expiration:** *04/20/2025*

Address: *336 NORTH MAIN STREET, WASHINGTON, PA 15301*

County: *WASHINGTON* **Region:** *WESTERN*

Administrator

Name: [redacted]

Legal Entity

Name: *PERSONAL CARE AT EVERGREEN INC*

Addre [redacted]

Phone

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *07/12/1999* **Issued By:** *Dept L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *43* **Waking Staff:** *32*

Inspection Information

Type: *Full* **Notice:** *Unannounced* **BHA Docket #:**

Reason: *Renewal, Complaint* **Exit Conference Date:** *04/18/2024*

Inspection Dates and Department Representative

04/02/2024 - On-Site: [redacted]

04/16/2024 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *48* **Residents Served:** *32*

Secured Dementia Care Unit

In Home: *No* **Area:** **Capacity:** **Residents Served:**

Hospice

Current Residents: *9*

Number of Residents Who:

Receive Supplemental Security Income: *1* **Are 60 Years of Age or Older:** *29*

Diagnosed with Mental Illness: *4* **Diagnosed with Intellectual Disability:** *3*

Have Mobility Need: *11* **Have Physical Disability:** *0*

Inspections / Reviews

04/02/2024 - Full

Lead Inspector [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *05/25/2024*

05/28/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *06/06/2024*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *06/04/2024*

05/30/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *06/06/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *06/06/2024*

09/16/2024 - Document Submission

Submitted By: [redacted] **Date Submitted:** *06/06/2024*

Reviewer: [redacted] **Follow-Up Type:** *Enforcement*

23a - Activities of Daily Living Assistance

1. Requirements

2600.
23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

Resident #1's assessment and support plan completed, [redacted]24, indicate that regarding toileting, resident is incontinent of urine and "needs assistance for all hygienic practices and that personal/peri care will be provided by staff with each and every episode of incontinence." However, on [redacted]24 at approximately 10:00 a.m., an aide from the resident's hospice agency made a visit to the home and observed that the resident's incontinence brief was saturated with urine to the point that it was sagging almost to [redacted]calves as he sat on the side of [redacted]bed. There was urine on the floor and the resident's bedding was saturated with urine.

Plan of Correction ***Directed [redacted] 05/30/2024)***

On 4/4/2024 Staff immediately assisted hospice in changing and cleaning up resident and also cleaned up residents' room, floor and changed the bedding. Resident #1 does not reside in facility anymore.
All staff was educated on personal care needs on 4/25/2024, by [redacted]with OSPTA.
All direct care staff are signing a daily assignment sheet at the end of each shift and submitting to Executive Director, this started on 5/13/24.
Beginning the week of 6/3/24 Executive Director will interview at least three residents a week for three months and then three residents a month for two months ending on 10/31/24, to ensure compliance with regulation 2600.23(a).
Sign in sheet, training material and daily assignment sheet attached.

Proposed Overall Completion Date: 10/31/2024

DIRECTED
Within 5 Calander days of the accepted plan of correction: The administrator shall ensure all aspects of the accepted plan of correction have been implemented. 5/30/24[redacted]

Directed Completion Date: *06/04/2024*

Licensee's Proposed Date for POC Implementation ***Implemented [redacted] 09/16/2024)***

25b - Contract Signatures

2. Requirements

2600.
25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

The contract for resident #1, completed [redacted]4, was not signed by the resident. The signature line only indicates "refused to sign."

The contract for resident #2, completed [redacted]23, was not signed by the resident. The signature line only indicates "refused."

The contract for resident #3, completed [redacted]24, was not signed by the resident.

25b - Contract Signatures *(continued)*

Plan of Correction ***Directed [redacted] - 05/30/2024)***

Resident #1,2 & 3 contracts have been signed.
[redacted] with Evergreen completed an audit of all contracts to ensure all have been signed by 5/20/24.
Beginning 6/3/24 Executive Director will monitor the next ten admission resident contracts to ensure all parties sign the contract in compliance with regulation 2600.25(b).
The only individual to ensure compliance with regulation 2600.25(b) is the Executive Director.
Attached is a copy of the chart review.

Proposed Overall Completion Date: 12/31/2024

DIRECTED
Within 5 Calander days of the accepted plan of correction: The administrator shall ensure all aspects of the accepted plan of correction have been implemented. 5/30/24 [redacted]

Directed Completion Date: *06/04/2024*

Licensee's Proposed Date for POC Implementation ***Implemented [redacted] - 09/16/2024)***

63a - First Aid/CPR Training

3. Requirements

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On 4/8/24, the home served 31 residents. However, there were no staff trained in first aid present in the home from 3:00 p.m. – 11:00 p.m. and there were no staff trained in first aid and certified in obstructed airway techniques and CPR present in the home from 11:00 p.m. through 7:00 a.m. on 4/9/24.

On 4/12/24, the home served 31 residents. However, there were no staff trained in first aid and certified in obstructed airway techniques and CPR present in the home from 3:00 p.m. through 11:00 p.m., and there were no staff trained in first aid from 11:00 p.m. through 7:00 a.m. on 4/13/24.

On 4/14/24 the home served 31 residents. However, there were no staff trained in first aid and certified in obstructed airway techniques and CPR present in the home from 7:00 a.m. through 11:00 p.m., and there were no staff trained in first aid from 11:00 p.m. through 7:00 a.m. on 4/15/24.

Plan of Correction ***Directed [redacted] 05/30/2024)***

On 5/7/2024 & 5/16/2024 CPR and 1st Aide Training was conducted by [redacted] with OSPTA.
Executive Director will conduct ongoing quarterly CPR and 1st Aide with OSPTA beginning August of 2024 to ensure regulation 2600.63(a) is met.
Executive Director will complete daily staffing assignment sheets and a biweekly schedule to ensure we have at least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR will be in the home at all times and that we are meeting regulation 2600.63(a). This scheduling has already started, 5/17/24.
Executive Director will complete a weekly review of schedule beginning 6/10/24, to ensure we have at least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR will

63a - First Aid/CPR Training (continued)

be in the home at all times and that we are meeting regulation 2600.63(a).
Training Sign in, Certificates and daily staffing assignment sheets are attached.

Proposed Overall Completion Date: 08/31/2024

DIRECTED
Within 5 Calander days of the accepted plan of correction: The administrator shall ensure all aspects of the accepted plan of correction have been implemented. 5/30/24

Directed Completion Date: *06/04/2024*

Licensee's Proposed Date for POC Implementation ***Not Implemented - 09/16/2024)***

65i - Training Record

4. Requirements

2600.
65.i. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

Description of Violation

There were no records of annual training for direct care staff person A, hired 15, for any required training topics in 2600.65f and 2600.65g for the staff training year 1/1/23 – 12/31/23.

There were no records of annual training for ancillary staff person B, hired 05, for any required training topics in 2600.65g for the staff training year 1/1/23 – 12/31/23.

Repeat violation 1/19/22 et al.

Plan of Correction ***Directed - 05/30/2024)***

Executive Director completed an employee file audit on all staff currently employed in the facility on 5/15/2024.
All staff were educated by Executive Director, on regulation 2600.65(i) on 5/22/2024.
Executive Director is developing a new staff training plan that will begin June 2024 and run to June 2025, to have monthly education's scheduled with staff to ensure all training topics are covered under regulation 2066.65(i) to include date of training, who conducted the training and the amount of time the training took.
Executive Director will audit staff training records quarterly in quality management meetings beginning July of 2024, to ensure compliance with regulation 2600.65(i).
Please see attached.

Proposed Overall Completion Date: 06/30/2025

DIRECTED
Within 5 Calander days of the accepted plan of correction: The administrator shall ensure all aspects of the accepted plan of correction have been implemented. 5/30/24

Directed Completion Date: *06/04/2024*

Licensee's Proposed Date for POC Implementation ***Implemented 09/16/2024)***

85a - Sanitary Conditions

5. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 4/2/24 at 10:37 a.m., the base cabinets in the kitchenette near rooms [redacted] are dirty with drips and particles of various foods on them. The base cabinet to the left of the refrigerator had white and brown streaks of spilled food. There is a sticky substance and crumbs along the baseboard of the cabinet to the left of refrigerator.

On 4/2/24 at approximately 11:00 a.m., there were food drips along the front of the two cabinets to the left of the refrigerator in the first-floor kitchenette near rooms [redacted] There is a red sticky substance on the top of the door of the cabinet closest to the refrigerator.

Plan of Correction ***Directed [redacted] - 05/30/2024)***

On 4/2/2024 kitchenette's were cleaned immediately by in-house staff.
Staff was educated by Executive Director, [redacted] on 5/22/2024 on regulation 2600.85(a).
Executive Director will monitor sanitary conditions daily M-F for 2 weeks and weekly for 2 months, beginning June 3, 2024 until August 9, 2024. See attached.
Photo and Training sign in attached.

Proposed Overall Completion Date: 08/09/2024

DIRECTED
Within 5 Calander days of the accepted plan of correction: The administrator shall ensure all aspects of the accepted plan of correction have been implemented. 5/30/24[redacted]

Directed Completion Date: *06/04/2024*

Licensee's Proposed Date for POC Implementation ***Not Implemented [redacted] - 09/16/2024)***

85b - Infestation

6. Requirements

2600.
85.b. There may be no evidence of infestation of insects or rodents in the home.

Description of Violation

On 4/2/24 at 10:53 a.m., there was an accumulation of very small wormlike insect carcasses at the bottom of the stairwell near room [redacted].

Plan of Correction ***Directed [redacted] - 05/30/2024)***

On 4/2/2024 infestation were cleaned immediately by in-house staff, facility exterminator comes monthly.
Staff was educated by Executive Director, [redacted] on 5/22/2024 on regulation 2600.85(b).
Executive Director will monitor infestation conditions daily M-F for 2 weeks and weekly for 2 months, beginning June 3, 2024 until August 9, 2024. See attached.
Photo and Training sign in attached.

Proposed Overall Completion Date: 08/09/2024

DIRECTED

85b - Infestation (continued)

Within 5 Calander days of the accepted plan of correction: The administrator shall ensure all aspects of the accepted plan of correction have been implemented. 5/30/24[redacted]

Directed Completion Date: *06/04/2024*

Licensee's Proposed Date for POC Implementation ***Implemented*** [redacted] ***- 09/16/2024)***

85d - Trash Receptacles

7. Requirements

2600.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 4/2/24 at 10:34 a.m., there was an uncovered small black trash can to the right of the refrigerator in the second-floor kitchenette near rooms [redacted].

Repeat violation 1/19/22 et al.

Plan of Correction ***Directed*** [redacted] ***- 05/30/2024)***

New trash receptacles with lids were purchased replacing all old cans by facility Maintenance Manager on 4/10/24.
Staff was educated by Executive Director, [redacted] *on 5/22/2024 on regulation 2600.85(d).*
Executive Director will monitor trash receptacles daily M-F for 2 weeks and weekly for 2 months, beginning June 3, 2024 until August 9, 2024. See attached.
Photo and Training sign in attached.

Proposed Overall Completion Date: 08/09/2024

DIRECTED
Within 5 Calander days of the accepted plan of correction: The administrator shall ensure all aspects of the accepted plan of correction have been implemented. 5/30/24[redacted]

Directed Completion Date: *06/04/2024*

Licensee's Proposed Date for POC Implementation ***Implemented*** [redacted] ***- 09/16/2024)***

86b - Bathroom

8. Requirements

2600.
86.b. A bathroom that does not have an operable, outside window shall be equipped with an exhaust fan for ventilation.

Description of Violation

On 4/2/24 at 10:25 a.m., the exhaust fan in the second-floor common half-bathroom to the right of the elevator was inoperable. There is no window in this bathroom.

Plan of Correction ***Directed*** [redacted] ***- 05/30/2024)***

On 4/11/2024 bathroom exhaust fan was replaced by facility Maintenance Manager.
Staff was educated by Executive Director, [redacted] *on 5/22/2024 on regulation 2600.86(b).*
Executive Director will monitor that exhaust fan are in good working conditions weekly for 2 months, beginning

86b - Bathroom (continued)

June 3, 2024 until July 26, 2024. See attached.
Photo and Training sign in attached.

Proposed Overall Completion Date: 07/26/2024

DIRECTED
Within 5 Calander days of the accepted plan of correction: The administrator shall ensure all aspects of the accepted plan of correction have been implemented. 5/30/24

Directed Completion Date: *06/04/2024*

Licensee's Proposed Date for POC Implementation ***Implemented (- 09/16/2024)***

88a - Surfaces

9. Requirements

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

On 4/2/24 at approximately 10:40 a.m., there were ripples in the carpeting in an area measuring approximately 14" X 2" in the common walkway outside of rooms There was also a ripple measuring approximately 3' X 3" outside of room These ripples in the carpeting pose tripping hazards.

On 4/2/24 at 10:56 a.m., the plaster on both sides on the door at the exit door at the bottom of the stairwell near room was crumbling and in disrepair.

Plan of Correction ***Directed - 05/30/2024)***

On 5/16/2024 new carpet was installed in all common areas by
On 4/9/24 the plaster on both sides of the exit door was repaired by facility Maintenance Manager.
Staff was educated by Executive Director, on 5/22/2024 on regulation 2600.88(a).
Executive Director will monitor surfaces for regulation 2600.88(a) weekly for 2 months, beginning June 3, 2024 until July 26, 2024. See attached.
Photo and training sign in attached.

Proposed Overall Completion Date: 07/26/2024

DIRECTED
Within 5 Calander days of the accepted plan of correction: The administrator shall ensure all aspects of the accepted plan of correction have been implemented. 5/30/24

Directed Completion Date: *06/04/2024*

Licensee's Proposed Date for POC Implementation ***Implemented 09/16/2024)***

94b - Non-Skid Surface

10. Requirements

2600.

94b - Non-Skid Surface *(continued)*

94.b. Interior stairs, exterior steps and ramps must have nonskid surfaces.

Description of Violation

On 4/2/24 at approximately 11:30 a.m., the paint/non-slip coating on the deck and steps outside of the kitchen exit is worn off seven 2"X 4" planks of decking extending along approximately three feet of the landing before the steps. The paint/coating is also worn off the two steps leading to the first landing. The non-slip coating is also worn off the first landing outside of the kitchen door. These areas were slippery in the rain on this date.

Plan of Correction ***Directed [redacted] 05/30/2024)***

On 5/21/2024 nonslip coating was applied to deck and steps by maintenance.
Staff was educated Executive Director, [redacted] on 5/22/2024 on regulation 2600.94(b).
Executive Director will monitor deck and step surface for regulation 2600.94(b) weekly for 2 months, beginning June 3, 2024, until July 26, 2024. See attached.
Photo and training sign in attached.

Proposed Overall Completion Date: 07/26/2024

DIRECTED
Within 5 Calander days of the accepted plan of correction: The administrator shall ensure all aspects of the accepted plan of correction have been implemented. 5/30/24 [redacted]

Directed Completion Date: *06/04/2024*

Licensee's Proposed Date for POC Implementation ***Implemented [redacted] 09/16/2024)***

103e - Left Overs

11. Requirements

2600.
103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

On 4/2/24 at approximately 10:40 a.m., there was an undated white Styrofoam bowl that contained sliced green peppers with slivers of ice on the peppers in the refrigerator in the first-floor kitchenette near rooms [redacted]

Repeat violation 1/19/22 et al.

Plan of Correction ***Directed [redacted] 05/30/2024)***

On 4/2/2024 undated food was removed from refrigerator by facility cook [redacted]
Staff was educated by Executive Director, [redacted] on 5/22/2024 on regulation 2600.103(e).
Executive Director will monitor leftovers in kitchenette areas daily M-F for 2 weeks and weekly for 2 months, beginning June 3, 2024 until August 9, 2024. See attached.
Training sign in attached.

Proposed Overall Completion Date: 08/09/2024

DIRECTED
Within 5 Calander days of the accepted plan of correction: The administrator shall ensure all aspects of the accepted plan of correction have been implemented. 5/30/24 [redacted]

103e - Left Overs *(continued)*

Directed Completion Date: *06/04/2024*

Licensee's Proposed Date for POC Implementation ***Not Implemented [redacted] - 09/16/2024)***

103f - Refrigerator/Freezer Temps

12. Requirements

2600.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

On 4/2/24 at 10:10 a.m., there was an open, half-full, 24oz bottle of Great Value tomato ketchup and an open 1/3 full 18oz bottle of Great Value Honey barbecue sauce setting on a brown wire tiered Kellogg's rack in the second-floor kitchenette near rooms [redacted] Both bottles have "refrigerate after opening" on them.

On 4/2/24 at approximately 11:00 a.m., there were two opened 8oz bottles of Great Value yellow mustard with "refrigerate after opening" on the labels setting on the stainless-steel prep table in the main kitchen. Staff person B, the cook, did not indicate that these bottles were removed from the refrigerator recently.

Plan of Correction ***Directed [redacted] 05/30/2024)***

On 4/2/2024 no- refrigerated food items were removed from kitchenettes by facility Cook, [redacted]
Staff was educated by Executive Director, [redacted] on 5/22/2024 on regulation 2600.103(f).
Executive Director will monitor non-refrigerated food items in kitchenette areas daily M-F for 2 weeks and weekly for 2 months, beginning June 3, 2024 until August 9, 2024. See attached.
Training sign in attached.

Proposed Overall Completion Date: 08/09/2024

DIRECTED
Within 5 Calander days of the accepted plan of correction: The administrator shall ensure all aspects of the accepted plan of correction have been implemented. 5/30/24 [redacted]

Directed Completion Date: *06/04/2024*

Licensee's Proposed Date for POC Implementation ***Not Implemented [redacted] 09/16/2024)***

105g - Lint Removal and Duct Cleaning

13. Requirements

2600.
105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

On 4/2/24 at approximately 11:10 a.m., there was approximately 1/16-inch layer of lint on the lint filter of the dryer on the far left in the laundry room off the kitchen. The dryer was empty.

Plan of Correction ***Directed [redacted] - 05/30/2024)***

On 4/2/2024 lint was removed from dryers by facility in-house DCS.
Staff was educated by Executive Director, [redacted] on 4/25/2024 on regulation 2600.105(g).

105g - Lint Removal and Duct Cleaning (continued)

Executive Director will monitor lint in dryers daily M-F for 2 weeks and weekly for 2 months, beginning June 3, 2024 until August 9, 2024. See attached.
Training sign in attached.

Proposed Overall Completion Date: 08/09/2024

DIRECTED
Within 5 Calander days of the accepted plan of correction: The administrator shall ensure all aspects of the accepted plan of correction have been implemented. 5/30/24 [redacted]

Directed Completion Date: *06/04/2024*

Licensee's Proposed Date for POC Implementation ***Implemented ([redacted] 09/16/2024)***

127a - Portable Space Heaters

14. Requirements

2600.
127.a. Portable space heaters are prohibited.

Description of Violation

On 4/2/24 at 4:40 p.m. there was a portable heater fan in use in bedroom [redacted]

On 4/2/24 at 4:42 p.m., there was a black space heater in use in bedroom [redacted]

Plan of Correction ***Directed [redacted] 05/30/2024)***

On 4/2/2024 portable space heaters were removed from bedroom [redacted] *by facility* [redacted] *was notified to come and pick them up.*
Staff was educated by Executive Director, [redacted] *on 4/25/2024 on regulation 2600.127(a).*
Executive Director will monitor resident rooms for portable space heaters weekly for 2 months, beginning June 3, 2024 until July 26, 2024. See attached.
Training sign in attached.

Proposed Overall Completion Date: 07/26/2024

DIRECTED
Within 5 Calander days of the accepted plan of correction: The administrator shall ensure all aspects of the accepted plan of correction have been implemented. 5/30/24 [redacted]

Directed Completion Date: *06/04/2024*

Licensee's Proposed Date for POC Implementation ***Implemented [redacted] - 09/16/2024)***

132b - Safety Inspection/Fire Drill

15. Requirements

2600.
132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

132b - Safety Inspection/Fire Drill *(continued)*

Description of Violation

The most recent fire safety inspection for the home was completed on 12/13/23. However, the previous fire safety inspection was completed on 6/7/22.

Plan of Correction ***Directed [redacted] 05/30/2024)***

Executive Director called [redacted] on 5/17/2024 to schedule next fire inspection before 12/13/2024.
Executive Director will begin monitoring fire safety inspection for the home starting July 1, 2024, and ending July 1, of 2025 to ensure the fire safety inspection is completed according to regulation 2600.132(b).

Proposed Overall Completion Date: 07/01/2025

DIRECTED
Within 5 Calander days of the accepted plan of correction: The administrator shall ensure all aspects of the accepted plan of correction have been implemented. 5/30/24 [redacted]

Directed Completion Date: *06/04/2024*

Licensee's Proposed Date for POC Implementation ***Implemented [redacted] - 09/16/2024)***

132d - Evacuation

16. Requirements

2600.
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

The most recent fire safety inspection for the home completed on 12/13/23 indicates that the maximum safe evacuation time for the home is 2 minutes and 52 seconds. On 3/15/24 at 9:00 a.m., the fire drill evacuation time was 2 minutes, 56 seconds.

The previous fire safety inspection completed 6/7/22 and expired on 6/7/23 indicated a maximum safe evacuation time of 2 minutes and 58 seconds. The maximum safe evacuation time default of 2 minutes and 30 seconds was in force from 6/7/23 – 12/13/23. However, the home's fire drills exceeded these times on the following dates and times:
** 10/17/23 at 5:21 a.m., the evacuation time was 3 minutes, 8 seconds.*
** 4/30/23 at 4:07 p.m., the evacuation time was 3 minutes.*

Plan of Correction ***Directed [redacted] 05/30/2024)***

Our evacuation time and safe areas is 2 minutes 58 seconds to evacuate all residents in the home, please see letter attached.
All staff are educated by Executive Director, [redacted] on 5/22/24, on regulation 2600.132(d).
Executive Director will monitor evacuation times monthly starting June 2024 for one year to ensure evacuations are conducted and facility is in compliance with regulation 2600.132(d).
Tracking sheet and training sign in attached.

Proposed Overall Completion Date: 06/01/2025

132d - Evacuation (continued)

DIRECTED

Within 5 Calander days of the accepted plan of correction: The administrator will complete the following steps to reduce the safe evacuation to a time less than 2 minutes and 30 seconds, if the home is unable to obtain a safe evacuation time specified in writing by a fire safety expert within the past year:

• Provide resident and staff education on evacuation policies and procedures. Documentation Shall be kept.

• Conduct additional fire drills if any fire drills exceed the fire safe evacuation time..

• Relocate residents who require special assistance with evacuation closer to exits or fire-safe areas.

• Add additional staff to meet the 2 minute and 30 second evacuation time or the safe evacuation time specified by the fire safety expert within the past year.

DIRECTED

Within 5 Calander days of the accepted plan of correction: The administrator shall ensure all aspects of the accepted plan of correction have been implemented. 5/30/24 [redacted]

Directed Completion Date: *06/04/2025*

Licensee's Proposed Date for POC Implementation ***Implemented*** [redacted] ***09/16/2024)***

[redacted]

162c - Menus Posted

18. Requirements

2600.

162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

162c - Menus Posted *(continued)*

Description of Violation

On 4/2/24 at 10:10 a.m., the menu posted in the kitchenette near room [redacted] and the menu posted on the second-floor bulletin board near the elevator, as well as all of the other menus posted in the home, ended on 4/3/24.

Plan of Correction ***Directed [redacted] - 05/30/2024)***

On 4/3/2024 current menu and 1 week in advance menu were posted in conspicuous public place by [redacted] Regional Director of Food Services.
Staff has been educated by Executive Director [redacted] on requirement 162(c) on 5/22/2024.
Executive Director will monitor weekly for 2 months starting June 3, and ending July 26, 2024, to ensure compliance of regulation 2600.162(c). See attached.
Photo and training sign in attached.

Proposed Overall Completion Date: 07/26/2024

DIRECTED
Within 5 Calander days of the accepted plan of correction: The administrator shall ensure all aspects of the accepted plan of correction have been implemented. 5/30/24 [redacted]

Directed Completion Date: *06/04/2024*

Licensee's Proposed Date for POC Implementation ***Implemented [redacted] - 09/16/2024)***

183d - Prescription Current

19. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On 4/2/24 at approximately 2:15 p.m., there was a box with pharmacy label for resident #2 that contained Ayr Saline Nasal Rinse kit and indicated – Rinse both sinuses once daily for 10 days. However, the medication was dispensed on 3/19/24 and there was a note indicating that it was started on 3/21/24 and therefore should have been discontinued on 3/31/24.

Resident #4's order for Levemir Flextouch pen was discontinued on 3/4/24. However, on 4/2/24 at 2:36 p.m., there was an opened Levemir Flextouch pen with pharmacy label for resident #4 that indicated – Inject 6 units sub-q daily at bedtime in the medication cart. The pen was marked as opened on "3/28." Staff person C who works for another home owned by the same legal entity was assisting during inspection and stated that he just marked the open date today by estimating when it would have been opened based on the amount of insulin remaining. Staff person C was not aware that the medication had been discontinued.

Plan of Correction ***Directed [redacted] - 05/30/2024)***

Both Ayr Saline Nasal Rinse Kit and Levemir Flextouch pen was removed from the cart on 4/2/24 by [redacted] completed a whole house cart audit on 5/5/24 to ensure all prescriptions are current.
All medication technicians were educated on regulation 183(d) by [redacted] Train the Trainer on May 2, 2024 and May 21 & 22, 2024.
Facility hired an LPN full-time that started on [redacted] 2024.
LPN will audit medication carts monthly starting 6/5/24, for two months and then quarterly after to ensure all

183d - Prescription Current (continued)

carts have current prescription in regard to regulation 2600.183(d).
Cart Audit and training sign in attached.

Proposed Overall Completion Date: 09/05/2024

DIRECTED
Within 5 Calander days of the accepted plan of correction: The administrator shall ensure all aspects of the accepted plan of correction have been implemented. 5/30/24

Directed Completion Date: *06/04/2024*

Licensee's Proposed Date for POC Implementation ***Implemented - 09/16/2024)***

184a - Resident's Meds Labeled

20. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
4. The prescribed dosage and instructions for administration.

Description of Violation

Resident #1 is ordered Lasix 40mg - 1 tablet by mouth daily and is also ordered Furosemide 40mg tablet – 1 tablet by mouth daily only as needed for crackles in lungs or fluid overload. On 4/2/24 at 3:25 p.m., the pharmacy label for this medication did not include instructions for use on an as needed (PRN) basis.

Plan of Correction ***Directed 05/30/2024)***

Furosemide 40mg tab 1 tablet by mouth daily only as needed label was fixed immediately by facility

completed a whole house cart audit on 5/5/24 and to ensure all resident's medications were labeled correctly.
All medication technicians were educated on regulation 184(a) by Train the Trainer on May 2, 2024 and May 21 & 22, 2024.
Facility hired an LPN full-time that started on 024.
LPN will audit medication carts monthly starting 6/5/24, for two months and then quarterly after to ensure all medication labels match in regard to regulation 2600.184(a).
Cart Audit and training sign in attached.

Proposed Overall Completion Date: 09/05/2024

DIRECTED
Within 5 Calander days of the accepted plan of correction: The administrator shall ensure all aspects of the accepted plan of correction have been implemented. 5/30/24

Directed Completion Date: *06/04/2024*

Licensee's Proposed Date for POC Implementation ***Not Implemented - 09/16/2024)***

185a - Implement Storage Procedures

21. Requirements

185a - Implement Storage Procedures *(continued)*

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident #1 is ordered albuterol sulfate 2.5mg/3Ml (0.083%) solution for nebulization – take 3 mL every 4 hours as needed for wheezing/shortness of breath. However, on 4/2/24 at 3:30 p.m., this medication was not available in the home.

On 4/2/24 at 1:55 p.m., there were two glucometers belonging to resident #3's Freestyle Libre glucose reading system. Neither glucometer was calibrated to current time; both glucometers were 1 hour behind current time.

Resident #3 is ordered blood glucose readings with varying sliding scale coverage, at breakfast, lunch, dinner, and before bed. However, the resident's April 2024 medication administration record (MAR) does not include the resident's blood glucose reading on 4/1/24 at 5:00 p.m.

Plan of Correction ***Directed [redacted] - 05/30/2024)***

[redacted] reordered the Albuterol Sulfate and calibrated both glucometers to the current time on 4/2/24.
[redacted] completed a whole house cart audit on 5/5/24 to ensure compliance with regulation 2600.185(a).
All medication technicians were educated on regulation 185(a) by [redacted] Train the Trainer on May 2, 2024, and May 21 & 22, 2024.
Facility hired an LPN full-time that started on [redacted] 2024.
LPN will audit medication carts monthly starting 6/5/24, for two months and then quarterly after to ensure all carts implement storage procedures in regard to regulation 2600.185(a).
Cart Audit and training sign in attached.

Proposed Overall Completion Date: 09/05/2024

DIRECTED
Within 5 Calander days of the accepted plan of correction: The administrator shall ensure all aspects of the accepted plan of correction have been implemented. 5/30/24 [redacted]

Directed Completion Date: *06/04/2024*

Licensee's Proposed Date for POC Implementation ***Not Implemented [redacted] - 09/16/2024)***

187a - Medication Record

22. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.

187a - Medication Record *(continued)*

10. Duration of therapy, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

Description of Violation

Resident #1 is ordered Ipratropium 0.03% spray – instill 1 spray into each nostril twice daily. However, the resident's April 2024 medication administration record (MAR) entry for this medication indicates – Instill 2 sprays into each nostril 2 times a day.

Resident #2 was ordered Ayr Saline Nasal Rinse kit– Rinse both sinuses once daily for 10 days. The medication was dispensed on 3/19/24. There was a note indicating that it was started on 3/21/24 indicating that the medication should have been discontinued on 3/31/24. However, on 4/2/24 at approximately 2:15 p.m., the medication was still listed on the resident's April 2024 medication administration record (MAR).

Resident #3 is ordered Insulin Aspart 100 unit/ml pen – inject SUB-Q per sliding scale with lunch: 80-150=3U; 151-200=4U; 201-250=5U; 251-300=6U; 301-350=7U; 351-400=8U; Above 400=8U. The resident's April 2024 MAR indicates that the resident's blood glucose reading on 4/1/24 at 12:00 p.m. was 479 but the MAR does not indicate the amount of insulin administered.

Repeat violation 1/19/22 et al.

Plan of Correction ***Directed [redacted] 05/30/2024)***

MAR for resident #1 was corrected to 1 spray not 2 on 4/2/24. Ayr Saline Nasal Rinse Kit was removed from cart immediately on 4/2/24, completed by [redacted] [redacted] completed a whole house cart audit on 5/5/24 to ensure compliance with regulation 2600.187(a).
All medication technicians were educated on regulation 187(a) by [redacted] Train the Trainer on May 2, 2024 and May 21 & 22, 2024.
Facility hired a LPN full-time that started on [redacted]/2024.
LPN will audit medication carts monthly starting 6/5/24, for two months and then quarterly after to ensure all carts all medication records are correct in regard to regulation 2600.187(a).
Cart Audit and training sign in attached.

Proposed Overall Completion Date: 09/05/2024

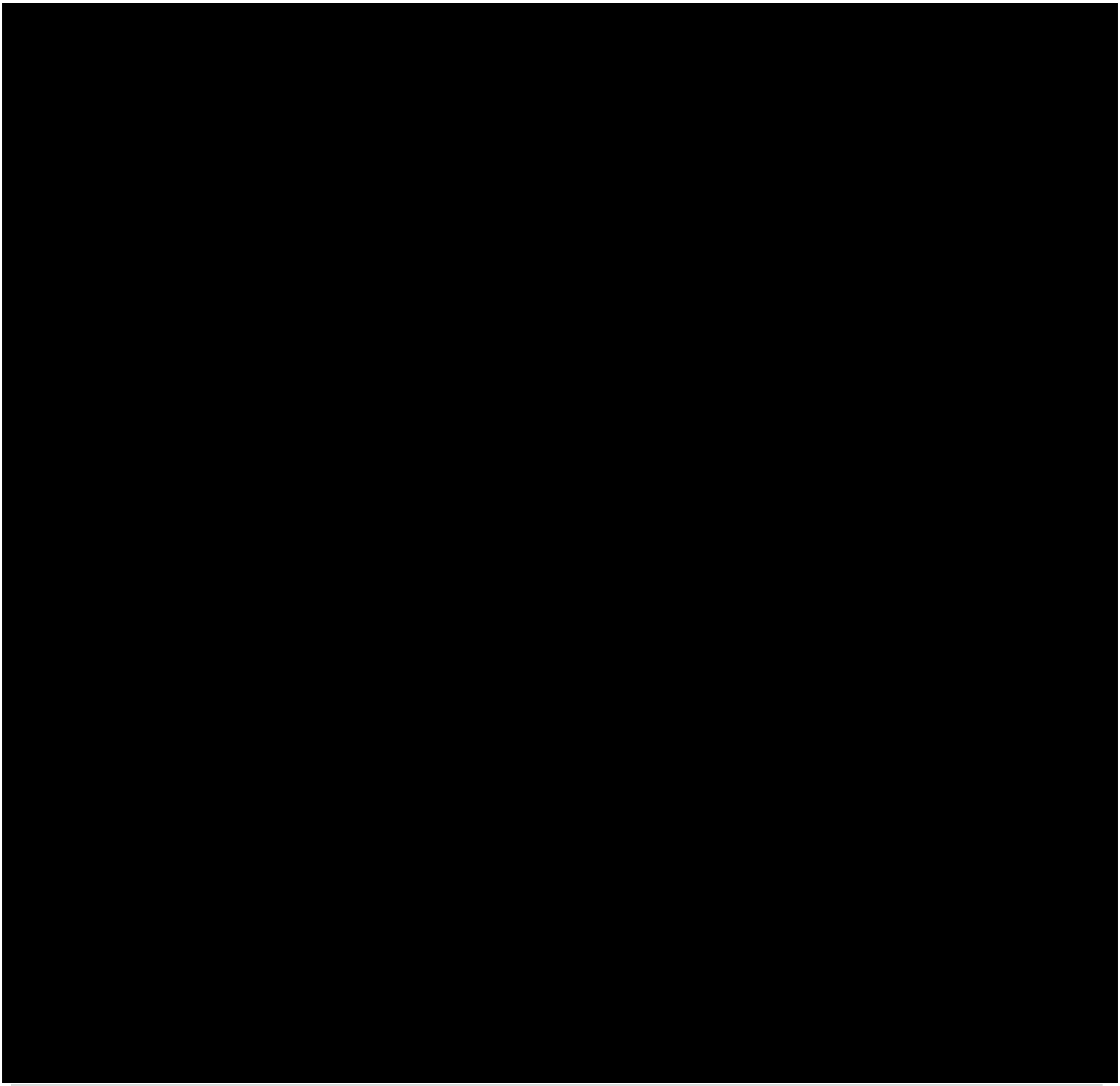
DIRECTED
Within 5 Calander days of the accepted plan of correction: The administrator shall ensure resident #2's medication was removed from the MAR or the resident's MAR is updated. 5/30/24 [redacted]

Within 5 Calander days of the accepted plan of correction: The administrator shall ensure resident #3's MAR is updated with the dose of Insulin Aspart 100 unit/ml pen – inject SUB-Q was administered. 5/30/24 [redacted]

Within 5 Calander days of the accepted plan of correction: The administrator shall ensure all aspects of the accepted plan of correction have been implemented. 5/30/24 [redacted]

Directed Completion Date: *06/04/2024*

Licensee's Proposed Date for POC Implementation ***Implemented ([redacted] 09/16/2024)***



24. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

As of [redacted]/24, resident #1 had been ordered 5 liters continuous oxygen. On 4/8/24 at approximately 8:30 a.m., a hospice aide went to resident's room and learned from staff in the room that he was having trouble getting air through his oxygen tubing. Hospice aide discovered that the water reservoir was not screwed on completely/correctly which caused the oxygen not to dispense properly. On 3/28/24, when hospice aide arrived, resident #1 was having an episode of shortness of breath.

187d - Follow Prescriber's Orders (continued)

Resident #3 is ordered insulin Aspart 100 unit/ml pen – Inject SUB-Q per sliding scale at bedtime: below 200=0U; 201-250=1U; 251-300=2U; 301-350=3U; 351-400=4U; over 400=5U. On 4/1/24 at 8:00 p.m., the resident's blood glucose measured 266 requiring 2 units of insulin. However, 6 units of insulin were administered.

Repeat Violation 1/19/22 et al.

Plan of Correction ***Directed [redacted] 05/30/2024)***

Resident #1 water reservoir was fixed immediately by hospice aide with Concordia on 4/8/24.
Resident #1 [redacted] was notified by hospice, hospice was notified by facility [redacted] on 4/8/24. Documentation kept in Tabula Pro by Executive Director.
Resident #3 family was notified by facility [redacted] on 4/1/24. MD was notified as well on 4/1/24. Documentation kept in Tabula Pro by Executive Director.
Executive Director will be submitting an incident report to the department on 5/30/24 by 3:00pm for the above incidents.
[redacted] completed a whole house cart audit on 5/5/24 to ensure all oxygen and blood glucose checks are being completed on all shifts.
Direct care staff were educated on regulation 187(d) on April 25, 2024 by OSPTA.
Facility hired a LPN full-time started on [redacted] 2024.
LPN will audit medication carts monthly starting 6/5/24, for two months and then quarterly after to ensure we are following prescribers orders in regard to regulation 2600.187(b).
Sign in sheet attached.

Proposed Overall Completion Date: 09/05/2024

Within 5 Calander days of the accepted plan of correction: The administrator shall ensure all aspects of the accepted plan of correction have been implemented. 5/30/24 [redacted]

Directed Completion Date: *06/04/2024*

Licensee's Proposed Date for POC Implementation ***Implemented [redacted] 09/16/2024)***

190a - Completion Medication Course

25. Requirements

2600.
190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff person D's initial medication administration certification was completed [redacted] /22. There have been no annual practicum recertifications since the initial certification. However, staff person D administered medication to the residents as follows:

** Resident #1 on 3/29/24 at 8:00 a.m., 9:00 a.m. and 2:00 p.m. and on 4/1/24 at 8:00 a.m. and 9:00 a.m.*
** Resident #2 on 4/1/24 at 8:00 a.m., 9:00 a.m. and 2:00 p.m.*
** Resident #3 on 4/1/24 at 8:00 a.m., 9:00 a.m. and 12:00 p.m.*
** Resident #4 on 4/1/24 at 8:00 a.m. and 9:00 a.m.*

190a - Completion Medication Course *(continued)*

Plan of Correction ***Accept [redacted] - 05/28/2024)***

Staff person D is no longer employed at the facility.
Executive Director did an employee file audit on 5/17/24.
Train the trainer came to facility and made sure all medication technicians currently employed at the facility received their trainings to be able to pass medications by 5/9/24.
Executive Director will audit medication technician certifications quarterly going forward to ensure we are compliance with regulation 2600.190(a).
Train the trainer audit attached.

Licensee's Proposed Overall Completion Date: *05/23/2024*

Licensee's Proposed Date for POC Implementation ***Implemented [redacted] - 09/16/2024)***

225a - Assessment 15 Days

26. Requirements

2600.
225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

Resident #1 was admitted to Concordia Hospice prior to admission to the home on [redacted]/24. However, the resident's initial assessment completed [redacted]/24 does not include contact information for Concordia Hospice. The assessment has contact information for OSPTA hospice.
As of 3/12/24, resident #1 is ordered 5l continuous oxygen. However, the resident's initial assessment completed 2/4/24 does not address this need nor the care of the equipment needed to provide supplemental oxygen.

Plan of Correction ***Directed [redacted] - 05/30/2024)***

Resident assessment was updated according to regulation 2600.225(a) by [redacted] Resident #1 no longer resides in the facility.
[redacted] completed an audit of all in house resident assessment and support plans to ensure compliance with regulation 2600.225(a).
LPN has been hired full-time on [redacted]24 to ensure compliance with regulation 2600.225(a).
Executive Director will monitor the new residents' assessments until September 2, 2024, to ensure compliance with regulation 2600.225(a).

Proposed Overall Completion Date: 09/02/2024

Within 5 Calander days of the accepted plan of correction: The administrator shall ensure all aspects of the accepted plan of correction have been implemented. 5/30/24 [redacted]

Directed Completion Date: *06/04/2024*

Licensee's Proposed Date for POC Implementation ***Implemented [redacted] - 09/16/2024)***

Department of Human Services
Bureau of Human Service Licensing

LICENSING INSPECTION SUMMARY - PUBLIC

Facility Information

Name: *PERSONAL CARE AT EVERGREEN* **License #:** *40578* **License Expiration:** *04/20/2025*

Address: *336 NORTH MAIN STREET, WASHINGTON, PA 15301*

County: *WASHINGTON* **Region:** *WESTERN*

Administrator

Name [redacted]

Legal Entity

Name: *PERSONAL CARE AT EVERGREEN INC*

Addre [redacted]

Phone

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *32* **Waking Staff:** *24*

Inspection Information

Type: *Partial* **Notice:** *Unannounced* **BHA Docket #:**

Reason: *Complaint, Interim* **Exit Conference Date:** *06/14/2024*

Inspection Dates and Department Representative

06/14/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *48* **Residents Served:** *24*

Secured Dementia Care Unit

In Home: *No* **Area:** **Capacity:** **Residents Served:**

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *3* **Are 60 Years of Age or Older:** *20*

Diagnosed with Mental Illness: *2* **Diagnosed with Intellectual Disability:** *1*

Have Mobility Need: *8* **Have Physical Disability:** *0*

Inspections / Reviews

06/14/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *07/28/2024*

Inspections / Reviews *(continued)*

07/25/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *09/12/2024*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *08/01/2024*

07/26/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *09/12/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *08/02/2024*

09/16/2024 - Document Submission

Submitted By: [redacted] **Date Submitted:** *09/12/2024*

Reviewer: [redacted] **Follow-Up Type:** *Enforcement*

63a - First Aid/CPR Training

1. Requirements

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On 6/10/24, the home served 24 residents. However, there was no staff trained in first aid and certified in CPR working in the building from 11:00 p.m. until 7:00 a.m. on 6/11/24.

On 6/11/24, the home served 24 residents. However, there was no staff trained in first aid and certified in CPR working in the building from 11:00 p.m. until 7:00 a.m. on 6/12/24.

Plan of Correction ***Accept [redacted] 07/26/2024)***

[redacted] *will ensure all staff currently working in the facility not trained in CPR will be trained by 7/29/24.*
All staff currently working in the facility will be educated on regulation 63a First Aid/CPR Training by 8/2/24.
Executive Director/Designee will monitor schedule and daily assignment sheets daily Monday though Friday for two weeks and then biweekly for two months starting 8/5/24 and ending 10/25/24.
Executive Director/Designee will also monitor all new hires starting [redacted]24 and ensure they receive First Aid/CPR Training within first 30 days of employment.
Executive Director/Designee will monitor CPR/First Aid Training and Certifications in quarterly Quality Management Meetings and will document findings starting August 2024.

Licensee's Proposed Overall Completion Date: *10/25/2024*

Licensee's Proposed Date for POC Implementation

85a - Sanitary Conditions

2. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 6/8/24 at 11:42 a.m., resident #1's glucometer was used to measure resident #2's blood glucose level.

Plan of Correction ***Accept [redacted] 07/26/2024)***

On 6/24/24 [redacted] ordered all new glucometers for residents currently residing in the facility. All glucometers have been calibrated and distributed.
Executive Director will review all glucometers to assure each glucometer is labeled to identify the specific resident it is to be used upon by 8/2/24.
All medication technicians will be educated by [redacted] on regulation 85a Sanitary conditions and will review and amend the home's policies regarding 2600.185a, specifically addressing the safe storage, access, distribution, and use of glucometers and testing equipment. A copy of the updated policy will be provided to and reviewed with all medication administration staff in the education by 8/2/24.
The home will notify each resident's [redacted]n (for those that receive blood sugar testing) of the possibility of shared glucometer use and all recommendations made by the physician will be followed, this will be done by Executive Director/RN/Designee by 8/2/24 and documentation will be kept for department review.

85a - Sanitary Conditions (continued)

Executive Director/Registered Nurse/Designee will monitor all glucometers starting 8/5/24 weekly for one month, biweekly for two months and monthly for three months ending on 1/6/25.
Executive Director/Medication Train the Trainer shall observe each staff responsible for medication administration completing blood glucose checks and administration of insulin medications once per week for a period of three months, then once per month for a period of three months. The documentation of observations will be kept for department review. This will begin the week of 8/5/24 and end 1/6/25.

Licensee's Proposed Overall Completion Date: *01/06/2025*

Licensee's Proposed Date for POC Implementation

95 - Furniture and Equipment

3. Requirements

2600.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

The closet closest to the window in resident #3's room is missing a door.

Plan of Correction ***Accept [redacted] 07/25/2024)***

Resident #3 room will have a new closet door installed by 8/2/24 by the [redacted]
All staff will be educated by [redacted] on regulation 95 and to report anything broken, damaged or in need of repair to ED and add work order to maintenance manager list by 8/2/24.
Executive Director/Designee will monitor resident rooms for repairs weekly Monday through Friday for two weeks and weekly for two months starting 8/5/24 and ending 10/25/24.

Licensee's Proposed Overall Completion Date: *10/25/2024*

Licensee's Proposed Date for POC Implementation

101j7 - Lighting/Operable Lamp

4. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

There was no operable lamp or other source of lighting that could be turned on at bedside for resident #3.

There was no operable lamp or other source of lighting that could be turned on at bedside for resident #4.

Plan of Correction ***Accept [redacted] 07/25/2024)***

Resident #3 and Resident #4 room will have a new lighting/operable lamps installed by 8/2/24 by the Maintenance Manager.
All staff will be educated by [redacted] on regulation 101j7 and to report anything broken, damaged or in need of repair to ED and add work order to maintenance manager list by 8/2/24.
Executive Director/Designee will monitor resident rooms for repairs weekly Monday through Friday for two weeks and weekly for two months starting 8/5/24 and ending 10/25/24.

101j7 - Lighting/Operable Lamp *(continued)*

Licensee's Proposed Overall Completion Date: *10/25/2024*

Licensee's Proposed Date for POC Implementation

103e - Left Overs

5. Requirements

2600.
103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

At 10:28 a.m., there was an undated, unlabeled, round black re-usable plastic container with a clear ridged lid in the refrigerator in the first-floor kitchenette near room [redacted] The contents appeared to be beets.

Plan of Correction *Repeat Violation 1/.19/22 et al* ***Accept[redacted] - 07/25/2024)***

The plastic container in the first-floor kitchenette was removed immediately on 6/14/24.
All staff will be educated by [redacted] on regulation 103e by 8/2/24.
Executive Director/Designee will monitor kitchenette refrigerators weekly Monday through Friday for two weeks and weekly for two months starting 8/5/24 and ending 10/25/24.

Licensee's Proposed Overall Completion Date: *10/25/2024*

Licensee's Proposed Date for POC Implementation

103f - Refrigerator/Freezer Temps

6. Requirements

2600.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

At 10:20 a.m., there was an opened, undated 64 oz bottle of Splash Diet Berry Blend juice beverage setting on the dry storage shelves in the home's kitchen. The label on the bottle indicated "must refrigerate promptly after opening and use within 14 days."

Plan of Correction ***Accept[redacted] - 07/25/2024)***

The juice beverage was removed immediately on 6/14/24.
All staff will be educated by [redacted] on regulation 103f by 8/2/24.
Executive Director/Designee will monitor storage area weekly Monday through Friday for two weeks and weekly for two months starting 8/5/24 and ending 10/25/24.

Licensee's Proposed Overall Completion Date: *10/25/2024*

Licensee's Proposed Date for POC Implementation

184a - Resident's Meds Labeled

8. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
4. The prescribed dosage and instructions for administration.

184a - Resident's Meds Labeled *(continued)*

Description of Violation

Resident #5 is ordered Humalog 100 units/ML Kwikpen – inject 10 units subcutaneously 3 times daily before meals. Resident is also ordered Insulin Lispro 100 unit/ml pen – Refer to Quickmar sliding scale calculator 4X/day before meals and at bedtime 70-140=0U; 141-180=2U; 181-220=4U; 221-260=6U; 261-300=8U; 301-340=10U; 341-400=12U Schedule daily at 8:00, daily at 12:00, daily at 17:00, daily at 20:00. However, at 1:55 p.m., there was a Humalog 100unit/ml Kwikpen with pharmacy label for resident #5 that indicates inject 10 units subcutaneously 3 times daily before meals. The label does not include directions for sliding scale insulin administration.

Plan of Correction ***Accept [redacted] 07/25/2024)***

On 7/24/24 the label was corrected for the Humalog 100unit/ml Kwikpen for resident #5.
All medication technicians will be educated by [redacted] on regulation 184a by 8/2/24.
Executive Director/Registered Nurse/Designee will monitor medication carts weekly starting 8/5/24 weekly for one month, biweekly for two months and monthly for three months ending on 1/6/25.

Licensee's Proposed Overall Completion Date: *01/06/2025*
Licensee's Proposed Date for POC Implementation

185a - Implement Storage Procedures

9. Requirements

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident #2 is ordered Blood glucose checks four times daily, before meals and at bedtime. According to resident #2's glucometer, the resident's blood glucose measured 92 on 6/13/24 at 11:14 a.m. However, this value was not entered on the resident's June 2024 medication administration record (MAR).

On 6/8/24 at 6:33 p.m., resident #2's glucose measured 209. However, 207 was entered on the resident's June 2024 MAR.

The glucometer for resident #5 was not calibrated to current date and time. At 2:06 p.m. on 6/14/24, the glucometer indicated it was "9:52 p.m. on 4/11."

Plan of Correction ***Accept [redacted] 07/26/2024)***

Resident #2 was not in the facility on 6/13/24 at 11:14am, please see documentation attached showing resident was out of facility with family and family administered medication not in the facility.
On 6/24/24 [redacted] ordered all new glucometers for residents currently residing in the facility with orders to have their blood glucose checked. All glucometers have been calibrated and distributed. All residents with scheduled blood glucose checks have been given an order for PRN blood glucose checks as well.
All medication technicians will be educated by [redacted] on regulation 185a by 8/2/24.
Executive Director/Registered Nurse/Designee will monitor medication carts weekly starting 8/5/24 weekly for one month, biweekly for two months and monthly for three months ending on 1/6/25.
Executive Director/Medication Train the Trainer shall observe each staff responsible for medication administration completing blood glucose checks and administration of insulin medications once per week for a period of three months, then once per month for a period of three months. The documentation of observations will be kept for

185a - Implement Storage Procedures (continued)

department review. This will begin the week of 8/5/24 and end 1/6/25.
Executive Director/Registered Nurse/Designee will monitor all resident MARs/blood glucose documentation for accuracy and completeness weekly starting 8/5/24 for one month, biweekly for two months and monthly for three months ending on 1/6/25.

Licensee's Proposed Overall Completion Date: *01/06/2025*

Licensee's Proposed Date for POC Implementation